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Communication Challenges Experienced in Lesotho Clinics Where Physicians Limitedly Speak both the Community Language and Lingua Franca

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ABSTRACT This study was aimed at exploring the challenges experienced by healthcare providers and patients in two clinics in Lesotho, staffed with physicians who limitedly speak both the community language and the lingua franca. Using a case study approach, semi-structured interviews, focus group discussions and observations were used to collect participants' experiences in consultations. Thematic content analysis was used to analyse the data. The results show that all groups of participants experience challenges with communication in the consultation. Doctors and patients cannot be certain of the accuracy of the information, while interpreters find the role as burdensome and challenging. These challenges emanate from the triadic nature of consultations and physicians' limited knowledge of both the community culture and language. The study concluded that language discordant consultations are problematic, so there is a need for formal provision of language services in multilingual health centres.

INTRODUCTION

Language discordant doctor-patient interactions are increasingly becoming a common feature of healthcare services due to increasing trends of multilingualism and mobility of doctors among the world populations as acknowledged in Gasiorek and van de Poel (2012).The potential implications that these interactions have on the achievement of effective communication between doctors and patients and the widely acknowledged value of communication in healthcare delivery (Paternotte et al. 2015; Rider et al. 2015) have created research interest on the issue among both health and linguistic researchers. In Lesotho healthcare centres, such interactions are very common because of the health system's heavy reliance on expatriate physicians, owing to shortage of local human resource capacity in the health sector and the burden of disease. Although recent statistics are not available, a study by Cohen (2009) indicated that 80 percent of physicians in Lesotho were expatriates at the time when their study was conducted, and Rosenberg and Weisfielder (2013) show that in 2008, there was a total of 89 doctors in Lesotho, most of which were expatriates. Research that provides insight into communication challenges presented by this scenario is essential in this context, in order to guide interventions that will enhance communication and healthcare delivery.

Statement of the Problem

Expatriate doctors in Lesotho are mostly from Francophone countries such as Congo, Cameroon and Gabon so they are mostly first language speakers of African languages such as Kiswahili, Lingala, Tshiluba, Ewondo and second language speakers of French. However, their work in Lesotho entails communicating with a patient base which is comprised of an overwhelming majority of Sesotho speakers, and clinical staff who are largely bilingual speakers of Sesotho and English. In order to operate in these settings, doctors have had to learn these two languages through interactions with clinical staff and patients, and they have some limited competency in them. It is this limited English and Sesotho that doctors use in consultations with patients, a situation that creates challenges not only for doctors but for patients and other clinical staff involved in the process of healthcare.

Recent research on language discordant doctor-patient interactions, for example, Hagiwara et al. (2013) and Patternote et al. (2015) has characterised them as communicatively challenging with a range of problems manifest during consultations. The most commonly noted prob-

lem in such settings is patients' inability to adequately express their concerns and reflect explanatory models of their illness to doctors and doctors' inability to explain diagnoses and treatment properly. This reportedly results in lack of mutual understanding of important aspects of the consultation such as the health problem presented and the risks and benefits of the proposed treatment plan (Elderkin-Thompson et al. 2001; Deumert 2010). Ultimately, patient satisfaction and adherence to treatment are compromised (Wiener and Riviera 2004; Babitsch et al. 2008; Hagiwara et al. 2013).

Another common challenge is the development of certain communicative behaviours which compromise the quality of care among doctors and patients, as observed in Desjarlais-de Klerk and Wallace (2013). Among doctors, these behaviours include the use of less effective and less empathic communication towards patients, rushing through the consultation agenda without checking the patient's understanding and demonstrating less socio-emotional exchange and stimulation of patient participation (Rivadeneyra et al. 2000; Meeuwesen et al. 2007; Schouten et al. 2009). This becomes problematic for achievement of positive health outcomes given that socio-emotional communication ultimately leads to better patient outcomes (Desjarlais-de Klerk and Wallace 2013). Among patients, the most notable communicative behaviour has been provision of minimal contribution to the consultation, thereby depriving healthcare providers an opportunity to get adequate details of the presented problem (Rivadeneyra et al. 2000; Meeuwesen et al. 2007). In other contexts patients have been found to lack linguistic and cultural adaptation to the healthcare services as noted in the work of Sandin-Vazquez et al. (2014).

These problems noted in past literature have been found to negatively affect the accuracy of diagnoses in some instances. The studies of Drennan and Swarts (2002) and Deumert (2010) established that when doctors do not fully comprehend patients' accounts, they tend to rely on accessible symptoms that have clear physical manifestations, despite common knowledge that such symptoms are prone to misinterpretation when used in isolation from detailed patient accounts. Diagnoses formed from these symptoms become fraught with mistakes consequently compromising the quality healthcare delivered and attainment of positive health outcomes (Elderkin-Thompson et al. 2001).

Although this body of literature provides ample research evidence of the specific challenges encountered in language discordant clinical interactions, most of that research was done in Europe and there are very few studies giving insights into challenges in Sub-Saharan Africa in Lesotho in particular. Moreover, available literature report on studies that were there are shared linguistic resources between doctors and other clinical staff, while patients are often migrants who speak a minority language. There has not been enough research attention paid to contexts like Lesotho healthcare centres where doctors only limitedly share a language with clinical staff and patients. This study bridges this gap by providing insight into communication challenges manifest in two HIV/AIDS care centres in Lesotho, where physicians limitedly speak Sesotho (the community language) and English (lingua franca).

Study Aims and Objectives

This study was aimed at establishing the communicative challenges experienced by healthcare providers and patients when doctors have limited proficiency in both Sesotho and English. The objectives of the study were to:

a) Identify communication challenges that are prevalent during the medical consultation,
b) Establish the ways in which participants react to such challenges,
c) Make recommendations meant to address these challenges.

METHODOLOGY

The study followed a case study approach as recommended by Mills et al. (2008) for healthcare research. The cases selected were two multilingual HIV/AIDS care clinics in Lesotho. Although these clinics differ in population size and physical structure, they are both multilingual spaces staffed by expatriate physicians. Most of these physicians have limited communicative competence in English and Sesotho. These two are official languages, predominantly used in the Lesotho healthcare system. While Sesotho is a community language spoken by a majority of the population in Lesotho, English is a lingua franca. Purposive sampling was used to select a sample representative of all participants that are involved in the process of patient care. The se-

lected sample size was 68 participants, comprised of 30 patients, 20 nurses 12, physicians, two lay interpreters, two administrative clerks and two counsellors.

Data was collected through the use of semi-structured interviews with staff and patients, focus group discussions with patients and observations of the communicative practices involved in the care process. The purpose of this triangulated approach was to reach data saturation and to allow for collection of different facets of data. The semi-structured interview guide was developed to mainly elicit data on participants' experiences of communication during the overall care processin order to extract specific challenges experienced. The focus group discussions elicited additional information on the challenges with a particular focus on patients, while observations provided data on the care process and communicative events involved in the process. The data were then fully transcribed and translated where necessary. Data was analysed through thematic and qualitative context analysis to determine the themes that recur in the transcripts.

RESULTS AND DISCUSSION

The results of this study illuminate a range of communication related challenges experienced by healthcare providers in linguistically diverse situations. These challenges threaten the quality of relationships among the different participants and their confidence on the success of communication during the consultation. The study also established that the challenging nature of language discordant consultations is experienced not only by different categories of clinical staff involved in patient care, but by patients. In this section the researcher gives a detailed discussion of the challenges experienced by participants. In the discussion, data excerpts that are in Sesotho are immediately followed by an English translation in brackets, in italics.

The Dynamics of Interpreter-Doctor Roles in a Consultation

In language discordant consultations, interpreting services are commonly used as a tool to facilitate communication. This resource has been deemed very valuable for the success of communication, despite concerns about the quality of interpreting noted for example, in the study of Kilian et al. (2014) and interpreters' tendency to go beyond their expected role and become active participants in the conversation (Angelelli 2004; Hsie 2007). Observations of the two clinics studied here reflect that although there are no written policies to guide the use of interpretation, the resource is the most prevalently used to facilitate communication between doctors and patients. There are no trained interpreters; therefore interpreting is done by either lay interpreters or bilingual staff depending on availability. In this paper, 'interpreters' refers to all the staff that is regularly involved as interpreters in consultations. Unlike in other studies where fellow patients or relatives were found to also interpret, in these cases interpreting is only done by staff.

An analysis of interpreters' descriptions of their interpreting role shows that the role is commonly constructed as challenging. The three most commonly cited sources of the challenges are:

a) Lack of formal training as interpreters or as language services providers among staff who regularly interpret;
b) Limitations of shared linguistic resources between doctors and clinical staff, thereby making communication problematic;
c) Patients' tendency to relate the history from far back in time, creating a need for interpreters to sift through the information and establish the current problem.

These factors, together with the scientific nature of medical communication, make medical interpreting a demanding task which involves message processing through filtering, reconstructing and reorganising information before interpreting it, while also simplifying medical information for patients to understand. This observation is also conceded to in the recent works of Raymond (2014) and Gavioli (2015). Adequate performance of this task therefore requires specialised skill and training in language services. However, in these two clinics this task is done by interpreters who are not capacitated to do so. This creates the challenge of prolonged consultations in these clinics that are already overpopulated with patients, and where time is of essence.

Another challenge that the study established is doctors' tendency to omit information that constitutes a pertinent component of the consultation, due to their limited vocabulary. Such

omissions leave interpreters with an added responsibility of firstly deciding what additional information has to be given to a patient, and secondly constructing the message in a manner that would be easily understandable to a patient. This added responsibility of making decisions on content relevance and on message organisation reconstructs interpreters' institutional role from just interpreting to being and active agents in message construction.

Interpreters' participation in content management and organisation creates a situation in which they assume a key conversational role in the consultation. Unlike in regular consultations whereas doctor is a key role-player with the responsibility of guiding and controlling information flow and quality (Salmon 2000; Heritage and Maynard 2006; Meeuwesen et al. 2007), in these cases those responsibilities lie with interpreters since they are the ones who solicit patients' problems, ask questions and ensure that the conversation flows well.

This key-role of interpreters is also evident in patients' discourses about their experiences in the consultation in that patients talk more about interpreters than they do about doctors. This expresses the level of visibility that interpreters have over that of doctors in a consultation. Due to the language barrier, doctors become invisible to patients and it becomes difficult for them to establish a rapport with their patients yet that is a crucial element for patient care. This has negative implications on the relationship between doctors and interpreting staff.

The study also established that this redefining of roles and relationships creates concerns about the quality of interpreting, among doctors and patients. Among doctors, the concerns emanate from their inability to: i) manage the accuracy and quantity of information being conveyed by interpreters to patients, and ii) repair the conversation where they feel that there are mistakes. One of the concerns doctors have is seen in the following excerpts from interviews with some of them:

…you can see sometimes they're translate(sic) the other things that you don't even want them to say then you say mhmhm!!! .Eh! ... You can see, you give one sentences, (sic) they give a lot of things.

Interview data from doctors shows three interpreting behaviours that are a source of discontentment among doctors, namely:

a) Passing additional self-constructed messages,
b) Censoring information,
c) Undermining the expertise and advice of doctors.

Although they do not have full linguistic access to the message content, these doctors form an opinion about the accuracy of interpreting by using the length of the interpreted message. Their limitations on communicative capacity also makes them feel deprived of the institutional power of conversational control that doctors often have in language concordant consultations (Heritage and Maynard 2006; Maynard and Frankel 2006).

It is not only doctors who have expressed concerns about the accuracy of interpreted information, but also patients. In the case of patients, concerns are around information to, and from them being censored by interpreters. Interpreters' involvement in information management therefore results in patient dissatisfaction with the consultation. As one patient puts it:

Joaloka motho a sa tsebeng, ke ee ke utloe eka hona le mantsoe ao a asiileng. Ke

utloe eka ha hlalosa a mang (mathata), ha ke tsebe haeba ke hobane ke sa tsebe puo eno, feela ke ee utloe eka hona le ntho tse setseng (As someone who doesn't know, I feel like there are words she omitted. I feel that she has not explained others (problems), I don't know whether it's because I don't know the language or not, but I feel like there are things she omitted…)

Given the dissatisfaction about interpreting among doctors and patients, it emerged that the two parties differ in the ways in which they handle the issue. Doctors expressed a sense of helplessness in the situation. An example of their reaction below was very common among doctors:

Sometimes you asking but eh...you can't even confirm, she tell you what she...she lie (sic) to you. You can't, you can't say if it's what she was tell the patient exact.

In some cases, doctors reportedly ask interpreters whether their messages were interpreted accurately, but they do not have confidence in the truth of the interpreters' reply. This means that the language barrier has also sown mistrust between doctors and interpreters. In other cases, they do not even ask because they feel like outsiders due to their limited ability to communicate with their patients and interpreters. This

implies that the consultation ends with doctors still uncertain of the accuracy of the message content.

Unlike doctors, patients report to have established a strategy of looking for communicative indicators that would give them a slight idea of the accuracy of interpreting. The following excerpt shows one of the indicators as expressed by patients:

Ha ke re hona le ntho mona (o supa lerao), ke ee utloe Doctor a re: hlobola, a tsebe ho sheba…, ha ke hlalositse hore meriana e mpha bothata kee bone a e chencha a mpha e meng. (When I say there is something here (points to buttock) I hear Doctor say I should undress,so she can check ...when I had explained that medication gives me problems I saw him/her changing and giving me a different type of medication).

In the above extract, the patient gives her account having in mind a set of expected reactions from the doctor. If the doctor's reactions correspond with the patient's expected reactions, there is confidence that the information was accurately conveyed. In some cases it was established that a patient seemingly consulted the doctor to verify information from a previous doctor. Confirmation of this prior diagnosis became a basis for assuming that the interpretation was accurate. Although this is not a reliable way of judging accuracy, it provides patients with a slight idea of whether the information was accurate or not and thus gives them patients some degree of satisfaction with the consultation.

It is apparent that these triadic consultations are problematic to all the parties involved. In particular, the inability to linguistically access the whole conversation seems to have sown distrust between interpreters and doctors. It also creates a feeling of being overworked among interpreters since the task is assigned to them on top of their nursing or administrative duties. The researcher argues that the language barrier reconstructs the institutional identities of doctors in a consultation. Instead of being in a position where they are managers and shapers of the conversational structure given their professional identity, they are less powerful than interpreters.

Lack of Cultural Competence

Language discordant consultations also subsume the existence of a cultural discordance because language and culture are interwoven as observed by Jiang (2000). Where there is cultural discordance between physicians and patients, communication tends to be insensitive to cultural practices and norms of the other party and that in turn compromises the quality of healthcare. Cultural competence is considered to be one of the very important aspects of healthcare delivery (Anderson et al. 2003; Acharya et al. 2013). Anderson et al. (2003) defines culturally competent care as one in which patient care is tailored to meet the social, cultural and linguistic needs of the patients. When healthcare providers lack awareness of their patients' culture, it becomes difficult to tailor care to these needs.

In this study, interpreters show that due to language and cultural discordance between patients and doctors, communication reflects signs of cultural incompetence, leading to provision of culturally insensitive advice to patient. In the following extract one of the interpreters relates a scenario that exemplifies this:

Ntho e nngoe ke hore….Lesotho mona liqeto tsa ho nyants'a le ho emisa ho nyants'a li etsoa ho buioanoe le ba bohali le monna, joal ofeela le ka taba ea ho etsa bana…mosali ha etse qeto e joalo a le mong. Joale ngaka tsena ka ho se tsebe ba laela bo-'m'e bana ho etsa lintho ba sa botsa. Ha ba sitoa ho etsa joalo ba ba offended ke ho se understande. (another thing is that here in Lesotho, decisions on breastfeeding and stopping are done in consultation with the marital family, just in the same as child-bearing. So these doctors just instruct these women on these issues, without knowing. When these women cannot comply they (doctors) get offended because they don't understand).

According to this interpreter, doctors' communication becomes culturally insensitive due to their lack of awareness of the importance of the extended family protocol in making decisions on childbearing and breastfeeding.

This cultural incompetence becomes offensive to patients and compromises patients' satisfaction with the consultation. This has negative implications on patient adherence to treatment and likelihood to come for follow-up consultations.

Doctors' Speaking and Communicative Styles that Compromise Effective Communication

The communicative and speaking styles of patients were found to be another factor that

posess a threat to the success of communication. The researcher uses speaking styles to refer to the phonological and phonetic characteristics of speech as acoustically perceived by the listener while communicative styles are verbal and non-verbal actions that are reflective of the social roles and identities of speakers (Giles 2008). Four aspects of physicians' speaking styles were identified as problematic to patients and interpreters.The first is the perceived complexity of the language used by physicians. This is characterised by:

a) The use of vocabulary unfamiliar to even patients who have some competency in English, for example, fatigue instead of tiredness.
b) Heavy reliance on scientific terms that is incomprehensible to patients and some of the lay interpreters for example, the use of hypertension in place of the commonly used "high blood".

Secondly, it is the accents of physicians, which are reportedly incomprehensible to patients and in some cases to other clinical staff. As mentioned before, most of the physicians come from Francophone countries; therefore their English accents are unfamiliar to first language speakers of Sesotho, who already have limited proficiency in English. Thirdly, it is the speed with which physicians speak. Patients and some of the clinical staff report that physicians speak very fast, thereby making their speech difficult to understand.

The fourth aspect found to be problematic was physicians' tendency of brevity. Physicians reportedly provide brief explanations of their understanding of the patients' problem and proposed treatment. They do this by:

a) Relying on the use of abbreviations due to inability to articulate lengthy explanations. This is exemplified in the following extract from an interview with an interpreter:
these doctors ... don't know English, they just know abbreviations, he/she just says to a patient: "PV discharge"… The patient doesn't know this, even if it's an English proficient one.
b) Providing cursory explanations of patients' conditions thereby furnishing patients with inadequate details of the problem. This is reportedly commonly encounteredwhen physicians interpret laboratory test results;
c) Giving very brief written records of patients' history, thereby depriving other health care providers (nurses, other physicians) who are going to be involved in patient treatment of essential detailed information.
d) If not attended to, these communication styles potentially effect patient satisfaction. When patients are not adequately informed about their condition, they leave the healthcare centre with unanswered questions and limited understanding of how the prescribed treatment will help. Such situations make interpreters an essential resource to facilitate understanding.

Staff Dissatisfaction

Another effect of the language barrier was found to be staff dissatisfaction mostly noticeable among administrative staff and nurses who are regularly tasked with interpreting. Among administrative staff and nurses, the source of dissatisfaction is that the language barrier has reconstructed their role, by adding interpreting to their duties. In describing their interpreting role, the following expressions were found to be common:

a. an additional workload that falls outside the scope of their duties,
b. a duty uncompensated for, yet it is very demanding,
c. a burden.

These descriptions reflect reasons for the discontentment of nurses and administrative staff about the interpreting duties. For them, interpreting duties are a human resource misplacement that positions them in a role they were not capacitated for through training, nor acknowledged for through compensation.

Apart from dissatisfaction with interpreting as a duty, nurses also expressed displeasure with the deployment and utilisation of lay interpreters as a resource to manage the language barrier and facilitate communication. Since lay interpreters are not trained as health nor language service specialists, the quality of their interpreting is reportedly flawed. Due to their limitations of knowledge in medicine and medical jargon, lay interpreters reportedly struggle to transfer some pieces of information from Sesotho to English or vice versa. Lay interpreters' mistakes generally fall under two categories:

a) Mistakes that arise out of limited knowledge to deal with linguistic issues. For example, where there is no direct Sesotho term for a particular concept, they struggle to provide accurate interpretation. A common example in this case was expression of pain intensity and aggression through Sesotho adjectives. Lay interpreters would reportedly avoid that detail thereby omitting a pertinent aspect of the pain, which would have given a clue for prognosis.
b) Mistakes that arise out of unfamiliarity with medical related vocabulary. This is exemplified in the following extract from an interview with one of the nurses.

…he (physician) was asking if a patient feels fatigued, this lay (interpreter) also failed to explain to the patient what fatigue is. She had to ask me after the consultation. But if it was me I would know what fatigue is, or if it was a nurse assistant he/she would know what fatigue is.

The lay interpreter's failure here is related to the fact that "fatigue" was not a familiar term for her. This unfamiliarity was not resolved during the consultation, which implies that the patient was denied an opportunity to respond to that question from a doctor. This would have been avoided if the interpreter had been given some training in medical vocabulary and language use.

Dissatisfaction was also noted among lay interpreters. For them the source of dissatisfaction is to work in a system where they have to interpret for doctors who do not have adequate communication competence in English. It is reportedly challenging and cognitively very demanding to facilitate communication in such cases. Their dissatisfaction was, however, moderate compared to that of nurses and administrative staff. This could be because of their gratitude for the job, since they have no formal training in either medicine or interpreting.

This trend of job dissatisfaction that cuts across all cadres of staff involved in patient care, has a potentially negative effect on the quality of service rendered to patients. In other studies (Drennan and Swarts 2002; Deumert 2010) staff dissatisfaction has been linked to patient dissatisfaction with the quality of care, which in turn has negative implications on adherence to treatment. Although in this study patient satisfaction was not tested, it can be deduced from the general dissatisfaction of staff that it is manifest.

CONCLUSION

The language barrier renders clinical consultations problematic for clinical staff, patients as well as expatriate doctors. The demand for language intervention in this health system that has no cadre of staff designated as medical interpreters puts nurses and administrative staff in a position where they have to render language services, a task they are neither trained for, nor compensated for. The difficulties of these ad hoc interpreters are further exacerbated by the limited communicative competencies of doctors in both the community language, and the lingua franca. Interpreting staff ultimately find themselves assuming a leading role in the consultation, a situation that causes dissatisfaction among doctors.This general dissatisfaction among healthcare providers seemingly compromises patient satisfaction too.

RECOMMENDATIONS

Given these challenges, it is essential to establish language intervention measures that would manage language diversity in a way that would benefit both healthcare providers and patients.This study recommends an introduction of language services as a formal component of healthcare. It would be beneficial if there could be accredited and certificated courses on language services in order to establish a trained cadre of staff dedicated to medical interpreting. As such developments are awaited, it is recommended that nurses and other bilingual staff who provide language services should be capacitated through formal training to equip them with skills needed for this duty. Since this is a separate task from their terms of reference, it is recommended that they are given separate compensation for it in orderto minimise dissatisfaction. There is also a need to develop induction programmes for expatriate staff to introduce them to the basics of the local language and culture in order to facilitate provision of culturally competent care. Furthermore, research into how other health systems manage similar language situations should be conducted to establish if there are other working measures that can be adapted to the Lesotho situation.

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